Philosophical Medical Ethics

On sickness and on health

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Part of the moral defence of Dr Arthur was based on the differentiation of various functions of the doctor: to preserve the lives of his or her patients, to restore or preserve their health, and relieve, prevent, or minimise their pain and suffering. In this article I shall consider briefly what we mean by health and the relation of health to what is usually considered its contrary—namely, ill health, especially those varieties of ill health we call illness and disease. I shall focus on aspects of these broad philosophical issues that seem particularly important in medical ethics.

Perhaps the best known definition of health is that of the World Health Organisation (WHO), according to which "health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity."[1] According to this definition, none of us is, has ever been, or is ever likely to be healthy. Thus it does not leave much scope for doctors to restore or preserve the health of their patients, as none of them will ever have had it to restore or preserve. If, however, we modify the requirement of the WHO definition so that the doctor's function is to help to achieve the health of his patients then his function becomes extremely wide,[2] for it will be to try to help people to achieve "a state of complete physical, mental, and social wellbeing," and everyone who has not achieved that ideal state—that is, everyone—becomes not healthy and a potential patient. Imagine all the causes of one's incomplete physical mental or social wellbeing—including lack of preseason physical training, inadequate understanding of arithmetic or astrophysics, not enough money, social status, or lovers—becoming the legitimate concern of doctors.

Inadequacy of WHO definition of health

Either the stated function of doctors or the broad definition of health requires modification, and there seem to be good grounds for modifying both. Firstly, the definition of health. Despite the etymology of the word "healthy," which derives from the Old English for "whole" (as does the cognate "hale"), we simply do not mean we are in a state of complete wellbeing when we say we are healthy. Rather we mean that we are in a state of adequate or sufficient wellbeing. The state of complete wellbeing described in the WHO account may be an ideal at which to aim, but it is not a definition of health if we accept that there are, in fact, plenty of healthy people about enjoying a state of wellbeing of which unhealthy people are deprived.

Even if we accept some modification of the WHO definition such that health is a state of *adequate* physical, mental, and social wellbeing, the definition still seems too broad for any account of medicine's functions which includes preservation or restoration of health, let alone achievement of health. This is because people achieve, maintain, and restore an adequate physical mental and social wellbeing—that is, health according to this modified definition—by various means, as I have indicated above. If to call something medical is to indicate that it is the appropriate concern of doctors then only some of those means would plausibly be regarded as medical. How are we to distinguish within the broad concept of health that aspect or subsector of health or wellbeing that is the appropriate concern of doctors and other health care professionals? One strategy might be to argue that any aspects of health with which doctors *et al* do as a matter of fact concern themselves are properly called medical aspects of health. This implies that any concern of doctors is properly called medical and is likely to be rejected by those outside the profession as "medical imperialism" the "expropriation of health" as Illich puts it[3]—and by those inside the profession as simply false.

Another approach is to differentiate the medical sphere of health concerns by reference to the sorts of impairments of health that are caused by ill health, notably illness and disease. On this account doctors would have the duty to restore and preserve those aspects of adequate wellbeing that have been impaired or are threatened by illness and disease. This seems to be getting closer to delineating the sorts of health concerns with which doctors are typically concerned and might avoid the awesome extension of a doctor's legitimate concerns into every aspect of human flourishing.

Realist and nominalist approaches

The problem then shifts to what we mean by ill health and its component concepts such as illness and disease. Such questions are extensively discussed (see bibliography), but two issues of particular relevance to medical ethics are the debate between realists and nominalists over whether there are such "things" as diseases, and the debate between those who argue that disease is necessarily an evaluative concept and those who claim that disease is a scientific concept free of values.

The first debate, at least in name, alludes to a hardy perennial of philosophical inquiry concerning the nature of universals—those properties of things that they share with other similar things.[4] If we accept the idiosyncratic use of realist/nominalist terminology in the debate about disease realists believe that the universal term "disease" refers to different types of entity or agent that cause different illnesses. Nominalists, on the other hand, such as Scadding and his colleagues, do not believe that there are such things as diseases, but that in medical discourse the name of a disease refers to "the sum of the abnormal phenomena displayed by a group of living organisms in association with a specified common characteristic or set of characteristics by which they differ from the norm of their species in such a way as to place them at a biological disadvantage."[5]

Apart from its intrinsic interest and the need for doctors to agree about what they mean when they use the term disease,[6] this debate is of some importance to medical ethics. One reason is that there exists, as Kennedy has noted, a tendency (though by no means a requirement) for realists to concentrate excessively on diseases and to fail to consider the whole person having the disease in his or her

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particular social context and environment.[7] On the other hand, nominalists risk the sort of subjectivism to which I have already referred—disease is simply whatever doctors decide is disease—indeed extreme nominalism leads to the extreme subjectivism of Humpty Dumpty: "Words mean what I chose them to mean."[4] Thus for the nominalist the potential scope of the concept of disease is exceedingly broad and can encompass a wide variety of what most would regard as non-medical "abnormal phenomena," which place people at "a biological disadvantage." For instance, as Toon points out,[8] under the above definition celibacy would count as a disease and, as Scadding *et al* cheerfully admit, so would poverty. Indeed it seems to me that even outstanding courage—for example, in battle—would count as a disease for is it not an abnormal phenomenon associated with specified common characteristics whereby its possessors differ from the norm of their species in such a way as to place them at a biological disadvantage? Scadding *et al* seek to overcome such objections to their definition by adding the discriminator (not in their definition but in their paper) of whether or not it is "useful" to define constellations of abnormal phenomena as diseases.[5] In what sense useful, useful to whom, and according to whom, we must ask?

Evaluation of disease

Such questions make clear how closely related the first debate between realism and nominalism is to the second one between those who regard disease as a value free concept and those who see it as necessarily evaluative. Scadding and his colleagues seem to be logically committed to a necessarily evaluative concept of disease. Thus the concept of "biological disadvantage" in their definition is evaluative, as is the concept of "useful," which they advocate as a discriminator for determining when constellations of abnormal phenomena that could be regarded as diseases should be so regarded.

A few stalwarts do argue that the concept of disease is value free (differentiating it from, for example, the concept of illness, in which the person's own evaluation of his symptoms plays an essential part). Thus Boorse argues that the concepts of both health and disease are non-evaluative and to be defined in terms of typical functioning for any particular species.[9] Health is analogous to the "perfect mechanical condition" of a motor car when it "conforms in all respects to the designer's detailed specifications": disease is "deviation from the natural functional organisation of the species" and a natural function is "nothing but a standard causal contribution to a goal actually pursued by the organism." I cannot do justice to his arguments here. Suffice it to say that they seem to entail either that any atypical functioning is a disease (the high jumper who clears 6 feet would then be diseased) or else that value laden concepts must be smuggled in to restrict the range of atypical functioning that can be called disease—for example, Boorse refers to "deficiencies" in the functional efficiency of the body and to "the action of a hostile environment" to pick out certain sorts of atypical functioning that he regards as diseases.

Definition of malady

But we still have not arrived at a plausible account of disease if all we are prepared to say is that it includes abnormal phenomena and characteristics that are negatively evaluated. Poverty in a society may fit these criteria and yet most people would be reluctant to classify it as a disease or illness. Several additional criteria have been proposed in excellent chapters on maladies and mental maladies by the psychiatric/philosophical team of Culver and Gert.[10] The first is that the evil or harm suffered by a person who has a malady (the authors' generic term for disease, illness, disability, infirmity, and so on) must be caused by something that is integral to and not separate from the person affected. Here they invoke the concept of a distinct sustaining cause whereby a "person has a malady if and only if the evil he is suffering does not have a sustaining cause which is clearly distinct from the person."

On this account poverty is not a disease, being caused by a distinct sustaining cause (lack of money), removal of which would rapidly ameliorate the evils or harms suffered by the poor person. On the other hand, poverty can itself cause various conditions—for example, nutritional deficiency or reactive depression—that are integral to the person, do cause harms, are not sustained by a distinct sustaining cause, and are thus maladies. A second criterion of malady is that the evil or harm may be risked rather than actually suffered, thus accounting for hidden or "lanthanic" disease[11] such as symptomless cancer discovered, say, on routine chest radiography, or symptomless high blood pressure. A third criterion is that if the harm or risk of harm is caused by the person's own rational beliefs or desires, or both, it is not a malady—refusal of blood by a Jehovah's Witness, participation in hang gliding, or outstanding courage in battle are thus not maladies even though they increase a person's risk of harm.

Culver and Gert do not pretend that their account of maladies is unproblematical, but they claim, and the claim seems justified, that it avoids many of the implausibilities and obscurities of earlier accounts. Moreover, it affords a unified account for physical and mental maladies. It is an account that repays thorough study. One important ambiguity that does seem to remain, however, is the question of whose evaluation is to count: the patient's, society's, or some combination. Even if one accepts the claim by Culver and Gert that the harms or evils suffered or risked by those who have maladies would be avoided by every rational person unless the person has good reason not to avoid them there is an obvious grey area where the person concerned may not consider the state a harm or evil and not wish to avoid it, while his or her society may disagree (some cases of narcotic addiction may provide an example[12,13]).

Question answered?

I have been unable even to outline an adequate answer to my question: What aspect of health is properly the concern of medicine and, more broadly, of the health care professions? I have, however, indicated what seem to be some important components of such an answer as well as at least one remaining grey area: Whose evaluation is to count, that of the person who has the disease or other malady, that of the doctor, or that of society?

Let me end by suggesting that as both the definition and ascription of illness and disease or malady are of such profound social importance and can literally make people's decisions invalid—for example, under the Mental Health Act they can excuse them from working or, more generally, from keeping their contractual obligations and can even protect them from being punished for serious offences under the law—and as these decisions are necessarily evaluative such decision making ought to be a cooperative venture between doctors and society: neither can legitimately make these decisions independently. Such cooperation is already manifested to some degree in certain legal and parliamentary processes but these are sporadic and tend to be resented by the medical profession. If the above claims are valid such resentment is inappropriate, and mechanisms for better and more consistent cooperation need to be developed both to bring the various health care professions together to think about these questions and to bring them and appropriate representatives of the societies of which they are a part together for the same purpose.

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Occupationless Health

Training and "work" for the unemployed

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People look to work for both money and a purpose, a sense of achievement, a time structure to the day, social contact outside the family, regularity, and social status.[1] Traditionally, a good full time job for life has met all these requirements, but for many people it may never do so again. As Handy has explained, not only has unemployment increased but also the nature of employment has changed.[2] A generation ago people would expect to work for 100 000 hours in a lifetime (47 hours a week for 47 weeks a year for 47 years), but now even those with jobs are down to 50 000 (37 hours a week for 37 weeks a year for 37 years). Some professionals may adopt yet another pattern and work long hours for fewer years, and some others—pop singers or sports stars—may work round the clock for just a few years.

But, Handy argues, in the 50 000 hours that people today have "spare" compared with their parents they will often be doing different sorts of work—unpaid work that will save them spending money (doing up the house), looking after dependants, working in the community, pursuing "hobbies" to "professional" standards. Maybe then these important categories of work that are still not regarded by many people as "proper work" will come to be more valued. Unemployment, meaning not having a paid job, might then come to be less painful and unhealthy if those without jobs found satisfaction in unpaid work and at the same time had an adequate income. Right now, however, this prospect seems rather far away as the unemployed feel unwanted and stigmatised, and their income is almost always much lower than when they had work.

This article will consider what is being done to help the unemployed find the satisfaction in their lives that has traditionally been found in paid employment, and the next will consider how their incomes might be increased.

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The Manpower Services Commission

Much is already being done to try to provide work and training for the unemployed, particularly the young unemployed, but the various programmes run by the Manpower Services Commission are not nearly as well known as they should be.[3] In their survey of social workers, health visitors, and health education officers in Scotland and the Midlands Popay *et al* found that knowledge of local initiatives funded by the Manpower Services Commission was very limited, especially among health professionals.[4] Yet the commission is in its second decade and in 1984-5 was operating 4000 youth training schemes for almost 400 000 youngsters as well as running many other programmes.

The aims of the commission are to "promote a more efficient labour market and competitive workforce" and to "help those at disadvantage in the labour market to overcome their employment problems." The youth training scheme is the largest single item in its budget, absorbing almost £800m in grants in 1984-5. The rhetoric of the scheme is that it is not a way of reducing youth unemployment but rather of "providing a permanent bridge between school and work." If this is its aim then it is not doing awfully well because in October 1985 only 48% of those emerging from the scheme were entering full time or part time work; a few were returning to full time education, and 9% were starting another youth training scheme, but 38% were going straight on to the dole.[5] Generally, as youth unemployment has risen the proportion of those emerging from the scheme and finding jobs has fallen.

The scheme aims at providing not only work experience but also training, and it is intended that some of the entrants to the scheme will already be in employment. In 1984-5 about 60% of 16 and 17 year old school leavers started on the scheme, which was rather less than expected. This was because more school leavers got jobs than had been predicted, more stayed at school, and 20 000 youngsters opted not to join the scheme. (Some young people are hostile to these schemes, labelling them slave labour—the training allowance has been £27·30 but is being raised to £35 a week.) There are three